Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DOLLY VINSANT HOSPITAL
302 KINGS HWY STE 112
BROWNSVILLE TX 78521

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number: 54

MFDR Tracking Number

M4-06-0098-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our position is that Carrier's grounds for denial are in violation of the TWCC Act. The TWCC has not assigned Maximum Allowable Rates for the services the subject of this claim. TWCC Rule 134.401(a)(4) specifically states that Ambulatory/Outpatient surgical care is not covered by the Acute Care Inpatient Hospital Fee Guidelines. If further states that such fees shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific types of reimbursement. In MDR: M4-04-1813-01, the Division ruled that evidence of redacted copies of payments made by the other carriers for similar treatment in the same geographical area was a proper method to determine the fair and reasonable rates. Furthermore, Dolly Vinsant asserts that no contractual relationship exist between it and Rockport Healthcare Group. The Agreement between Dolly Vinsant and carrier's representative, (Newton Healthcare Network, LLC), became invalid in 1998."

Amount in Dispute: $9,268.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This dispute involves the carrier's payment for date of service 10/05/2004 to 10/05/2004 for which the requestor charged $10,460.00; Texas Mutual paid $1,191.60. The requestor believes it is entitled to an additional $9,268.40; Texas Mutual does not for the following reasons. 1. Texas Mutual Insurance Company received your request for additional information regarding the medical benefits dispute with the requestor. The issue in dispute is the requestor's a) failure to substantiate that its usual and customary fee for the service in dispute is fair and reasonable as required by Commission Rule 134.1(f) and Section 413.011(b) of the Texas Labor Code; and b) failure to prove this carrier's payment is not fair and reasonable. Texas Workers' Compensation Commission contracted with Ingenix to develop a hospital outpatient payment fee guideline. The Texas Workers' Compensation Commission Ingenix Summary 2002 (Exhibit 3) recommended overall market reimbursement level of 140% of the Medicare Hospital Prospective Payment System (HOPPS) as a fair and reasonable reimbursement in accordance with Section 413.011(d) of the Texas Labor Code. The requestor obtained pre-authorization for Bilateral Lumbar Transforaminal Epidural Steroid Injection at L4 and L5. However. The Table of Disputed services lists 64484 in dispute and Texas Mutual made a fair and reasonable reimbursement for treatment 64484, based on the Commission's Ingenix study. 140% of the HOPPS payment associated with code 64484 results in reimbursement in the amount of $739.64. This carrier has reimbursed the requestor $1,191.60, therefore, no further reimbursement is due, as this carrier has allowed above the fair and

reasonable amount indicated by Ingenix. The requestor has only submitted redacted EOB's to support its assertion the billed amount is fair and reasonable. While EOB's are some evidence of fair and reasonable, they are not the sole basis. In the absence of any other information from the requestor, it is the carrier's osition that the amount billed, $10,460.00 is not fair and reasonable."

Response Submitted by: Texas Mutual Insurance Co., 6210 E. Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
October 5, 2004	Outpatient Surgery	$9,268.40	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on August 30, 2005. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on September 9, 2005 to send additional documentation relevant to the fee dispute as set forth in the rule.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – Workers Compensation State Fee Schedule Adjustment.
   - W10 – No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.
   - 24 – Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.
   - 713, 894 – Fair and reasonable reimbursement for the entire bill is made on the "O/R Service" line item.
   - 790 – This charge was reduced in accordance to the Texas Medical Fee Guideline.
   - 793 – Reduction due to PPO Contract. PPO Contract was applied by Rockport Healthcare Group Network partner Rockport Healthcare Grp.
   - W4 – No additional reimbursement allowed after review of appeal/reconsideration.
   - 420 – Supplement payment.
   - 891 – The insurance company is reducing or denying payment after reconsidering a bill.

Findings

1. The Requestor states that the payment received was $953.29; however, the Respondent has submitted an EOB, dated August 10, 2006, showing an additional payment of $240.08 was made.
2. Claim adjustment code 24 noted, in part, that the reason for reduction was due to a "Payment charges adjusted. Charges are covered under a capitation agreement/managed care plan." No documentation was found to support that such an agreement existed between the parties in dispute, for the date of service in dispute. For that reason, the Division concludes that these reasons are unsupported. Consequently, the services in dispute will be reviewed per applicable Division rules and fee guidelines
3. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It

further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

5. 28 Texas Administrative Code §133.307(e)(2)(A), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include "a copy of all medical bill(s) as originally submitted to the carrier for reconsideration…" Review of the documentation submitted by the requestor finds that the request does not include a copy of the medical bill(s) as submitted to the carrier for reconsideration. The Division concludes that the requestor has not met the requirements of §133.307(e)(2)(A).
6. 28 Texas Administrative Code §133.307(e)(2)(B), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include "a copy of each explanation of benefits (EOB)… relevant to the fee dispute or, if no EOB was received, convincing evidence of carrier receipt of the provider request for an EOB." Review of the documentation submitted by the requestor finds that the request does not include a copy of the EOB detailing the insurance carrier's response to the request for reconsideration. Neither has the requestor submitted convincing evidence of carrier receipt of the provider request for an EOB. The Division concludes that the requestor has not met the requirements of §133.307(e)(2)(B).
7. 28 Texas Administrative Code §133.307(g)(3)(B), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including "a copy of any pertinent medical records." Review of the submitted documentation finds that the requestor has not provided copies of all medical records pertinent to the services in dispute. Although the requestor did submit a copy of the operative report, the requestor did not submit a copy of the anesthesia record, post-operative care record, or other pertinent medical records sufficient to support the services in dispute. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(B).
8. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:

   - The requestor's position statement / rationale for increased reimbursement from the *Table of Disputed Services* asserts that "In MDR: M4-04-1813-01, the Division ruled that evidence of redacted copies of payments made by the other carriers for similar treatment in the same geographical area was a proper method to determine the fair and reasonable rates."
   - The requestor does not discuss or explain how "redacted copies of payments made by other carrier for similar treatment…" supports the requestor's position that the amount sought is a fair and reasonable reimbursement for the services in this dispute.
   - In support of the requested reimbursement, the requestor submitted redacted explanations of benefits, and selected portions of EOBs, from various sample insurance carriers. However, the requestor did not discuss or explain how the sample EOBs support the requestor's position that additional payment is due. Review of the submitted documentation finds that the requestor did not establish that the sample EOBs are for services that are substantially similar to the services in dispute. The carriers' reimbursement methodologies are not described on the EOBs. Nor did the requestor explain or discuss the sample carriers' methodologies or how the payment amount was determined for each sample EOB. The requestor did not discuss whether such payment was typical for such services or for the services in dispute.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

		January 19, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.